



Molina Healthcare of Nebraska, Provider Notice

CCBHC Billing Guideline for Dual-Eligible Members

04/15/2026

Purpose:

This guideline outlines billing requirements for Certified Community Behavioral Health Clinics (CCBHCs) serving dual-eligible members (Medicare and Medicaid) enrolled with Molina Healthcare of Nebraska, to ensure accurate coordination of benefits (COB) and proper payment of the Prospective Payment System (PPS) encounter rate.

Scope:

Applies to all CCBHC providers billing Molina Healthcare of Nebraska for services rendered to members who have:

- Medicare Advantage as primary, or
 - Medicare Fee-For-Service (FFS) as primary
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General Billing Principles

- All applicable primary payer sources must be exhausted before billing Medicaid for CCBHC PPS services.
 - Molina will coordinate benefits and reimburse up to the PPS encounter rate, less any payment made by the primary payer.
 - Documentation supporting coordination of benefits (e.g., Medicare EOB) is required.
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Scenario 1: Medicare Advantage as Primary

Billing Requirements

1. Bill ALL services associated with the encounter to the primary payer, including:
If you have general questions about this communication, please contact our Provider Relations Team at NEProviderRelations@MolinaHealthcare.com.



- Medicare-covered services
 - Medicare-exempt services
 - T1040 (PPS Encounter Code)
2. Allow the primary payer to process the claim.
 3. Submit a claim to Molina Healthcare of Nebraska that includes:
 - All services rendered for the encounter
 - The Medicare Advantage EOB

Molina Payment Methodology

- Molina will coordinate benefits using the primary payer EOB.
 - Payment will be made up to the PPS encounter rate, minus the amount paid by the primary payer.
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Scenario 2: Medicare Fee-For-Service (FFS) as Primary

Initial Medicare Billing

1. Bill ONLY Medicare-covered services to Medicare FFS. *
2. Do not include Medicare-noncovered services on the Medicare claim. *

Medicare Crossover to Molina

- Molina will receive the Medicare crossover claim.
- If the crossover claim does not include the PPS encounter code (e.g., T1040):
 - Molina will deny the claim in accordance with CCBHC billing requirements.

Corrected Claim Submission

Once the denial is received:

1. Submit a corrected claim to Molina that includes:
 - ALL services associated with the encounter (Medicare-covered and noncovered)
 - The PPS encounter code
 - The Medicare EOB

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2. Molina will accept the corrected claim even if the EOB does not exactly match all services billed.

Molina Payment Methodology

- Molina will coordinate the corrected claim with the Medicare EOB.
- Payment will equal:
 - PPS encounter rate, minus
 - Medicare payment amount
- The combined Medicare and Medicaid payments will not exceed the PPS encounter rate.

Key Compliance Notes

- Failure to include the T1040 PPS encounter code on Medicaid claims will result in denial.
- Failure to include the qualifying service(s) on Medicaid claims will also result in denial.
- Medicare EOB documentation is required to support coordination of benefits.
- Providers must ensure services billed to Molina reflect the full encounter when submitting corrected claims.
- Only one PPS encounter payment per member per day is permitted.

** Footnote:*

It may be beneficial for the provider to work with their clearinghouse and Medicare contacts to determine whether claims can be submitted in a manner that allows Medicare noncovered services to be billed and result in a service-level denial rather than a claim rejection, when appropriate. This can help support downstream billing and secondary payer processing.

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